

A. Demographic			EDN TB Follow-Up Worksheet		Last reviewed: 6/21/2013	
A1. Name (Last, First, Middle):		A2. Alien #:		A3. Visa type:		A4. Initial U.S. entry date:
A5. Age:	A6. Gender:	A7. DOB: _____/_____/_____		A8. TB Class:		
A9. Country of examination:				A10. Country of birth:		
A11a. Address:				A12. a. Sponsor agency name:		
A11b. Phone:				b. Phone(s):		
A11c. Other:				c. Address:		
B. Jurisdictional Information						
B1. Arrival jurisdiction:			B2. Current jurisdiction:			
C. U.S. Evaluation						
C1. Date of Initial U.S. medical evaluation: _____/_____/_____						
Mantoux Tuberculin Skin Test (TST)				Interferon-Gamma Release Assay (IGRA)		
C2a. Was a TST administered? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				C3a. Was IGRA administered? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
If YES, C2b. TST placement date: _____/_____/_____				If YES, C3b. Date collected: _____/_____/_____ <input type="checkbox"/> Date unknown		
<input type="checkbox"/> Placement date unknown				C3c. IGRA brand: <input type="checkbox"/> QuantiFERON® <input type="checkbox"/> T-SPOT		
C2c. TST mm: _____ <input type="checkbox"/> Unknown				<input type="checkbox"/> Other (specify):		
C2d. TST interpretation: <input type="checkbox"/> Positive <input type="checkbox"/> Negative				C3d. Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		
<input type="checkbox"/> Unknown				<input type="checkbox"/> Invalid <input type="checkbox"/> Unknown		
C2e. History of Previous Positive TST <input type="checkbox"/>				C3e. History of previous positive IGRA <input type="checkbox"/>		
U.S. Review of Pre-Immigration CXR			U.S. Domestic CXR		Comparison	
C4. Pre-immigration CXR available? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Verifiable			C7. U.S. domestic CXR done? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		C11. U.S. domestic CXR comparison to pre-immigration CXR:	
C5. U.S. interpretation of pre-immigration CXR:			If YES, C8. Date of U.S. CXR: _____/_____/_____		<input type="checkbox"/> Stable <input type="checkbox"/> Worsening <input type="checkbox"/> Improving <input type="checkbox"/> Unknown	
<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (must select one below): <input type="checkbox"/> Not consistent with active TB <input type="checkbox"/> Non-cavitary, consistent with TB <input type="checkbox"/> Cavitary, consistent with TB <input type="checkbox"/> Poor Quality <input type="checkbox"/> Unknown			C9. Interpretation of U.S. CXR:			
<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (must select one below): <input type="checkbox"/> Not consistent with active TB <input type="checkbox"/> Non-cavitary, consistent with TB <input type="checkbox"/> Cavitary, consistent with TB <input type="checkbox"/> Unknown			<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (must select one below): <input type="checkbox"/> Not consistent with active TB <input type="checkbox"/> Non-cavitary, consistent with TB <input type="checkbox"/> Cavitary, consistent with TB <input type="checkbox"/> Unknown			
C6. Other pre-immigration CXR abnormalities: <input type="checkbox"/> Volume loss <input type="checkbox"/> Infiltrate <input type="checkbox"/> Granuloma(ta) <input type="checkbox"/> Adenopathy <input type="checkbox"/> Other (specify)			C10. U.S. domestic CXR abnormalities: <input type="checkbox"/> Volume loss <input type="checkbox"/> Infiltrate <input type="checkbox"/> Granuloma(ta) <input type="checkbox"/> Adenopathy <input type="checkbox"/> Other (specify)			
U.S. Review of Pre-Immigration Treatment						
C12a. Completed treatment pre-immigration? <input type="checkbox"/> Yes <input type="checkbox"/> No				C13. Arrived on treatment?		
If YES, <input type="checkbox"/> Treated for TB disease <input type="checkbox"/> Treated for LTBI				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
C12b. Treatment start date: _____/_____/_____ <input type="checkbox"/> Start date unknown				If YES, <input type="checkbox"/> TB disease <input type="checkbox"/> LTBI		
C12c. Treatment end date: _____/_____/_____ <input type="checkbox"/> End date unknown				C13a. Start date: _____/_____/_____ <input type="checkbox"/> Start date unknown		
C12d. Treatment reported by:				C14. Pre-Immigration treatment concerns?		
<input type="checkbox"/> Treatment documented on DS forms				<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Patient reported treatment completion at or before panel physician examination				If YES,		
<input type="checkbox"/> Both-documented on DS forms & patient reported				<input type="checkbox"/> Treatment duration too short		
<input type="checkbox"/> Unknown				<input type="checkbox"/> Incorrect treatment regimen		
C12e. Standard TB treatment regimen was administered?				<input type="checkbox"/> Other, please specify:		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to verify						

